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Our Community

Presented by
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There is much to be gleaned from "best practice" eye care delivery models. Moreover, opportunities should be created to duplicate them in community and rural health care settings to help reduce health disparities among underserved populations.

Barriers

Much has been said regarding inadequate access to health care in the rural setting. It is evident that geographic distance from health care providers and facilities has a negative impact on the timely delivery of all health care. Just as important is the socioeconomic barrier that exists in deep urban settings. Although providers and facilities may be available within short geographic reach to these underserved urban populations, the health care isolation of these populations is evident in the increased incidence of disease within "at risk" aging populations. In many urban environments a concentration of high-level medical facilities and providers exist. However, access to these providers is usually through geographically concentrated hospitals or centers within the urban setting. An example of this is Parkland Hospital in Dallas, TX, a highly respected urban medical training center with an excellent ophthalmology department. However, just blocks away is the Dallas Housing Authority where a significantly "at risk" population exists. A patient who cannot afford glaucoma medications to maintain sight must wait up to 8 months for a glaucoma laser procedure while they continue to lose their vision.

Solutions:

Create and maintain community optometric centers within urban areas.

Create incentives, such as loan forgiveness, for optometric providers who participate in care at the highest levels, including laser and minor surgical procedures, within these urban settings.

Create and offer provider incentives for overlapping clinical training between family practice physicians and optometrists. There is much that a family practice physician could learn about eye signs of systemic disease within an eye clinic, and there is much that optometrists could learn about systemic disease from rotations within family practice clinics – all of which could be directly applicable to an at-risk aging urban population.

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The concept of “Pay for Performance” is being discussed within CMA. Allow private practitioners who provide services within underserved urban areas to participate in “Pay for Performance” reimbursement rates.